Prevention Evaluation Perspectives

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Community Coalitions:

Questions, Controversy & Context

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The crack cocaine outbreak of the 1980's was a catalyst for the beginnings of what we know as community coalitions today (DrugStrategies, 2001). In Miami (the "cocaine capital") concerned citizens mobilized to pool resources, take ownership of the cocaine problem, and develop long-term solutions. Many communities followed suit and organized coalitions across the country in response to similar concerns, and in 1990 the first national meeting of community coalitions occurred (DrugStrategies, 2001). At that time the Community Anti-Drug Coalitions of America (CADCA) emerged as the voice for these grass-roots coalitions. This sparked a whole movement, with the private sector (e.g. foundation community) rapidly becoming involved by contributing significant funding and technical support to fledging coalitions. The Federal Government also made considerable contributions to the coalition movement, with the Community Partnership Demonstration Grant Program (administered by the Center for Substance Abuse Prevention) providing major funding to 251 community partnerships (Drug Strategies, 2001). Later, key politicians backed legislation to provide continued Federal support for coalitions. The Drug Free Communities Act was adopted in 1997 by Congress, and provided support for long-term commitments to reduce substance abuse in youth (Drug Strategies, 2001). More recently, President Bush requested increased funding for the Drug Free Communities Program. Coalitions have definitely "arrived" and have become an accepted approach for community intervention in many areas, including substance abuse.

Kentucky and Community Coalitions

Kentucky, along with several other States, has made substantial efforts to prevent and reduce the harmful consequences that can result from problem substance use. The KY Department of Mental Health and Mental Retardation, Division of Substance Abuse (DSA) provides policy direction, program funding and program monitoring for substance abuse treatment programs. In addition, the DSA administers and supports a statewide prevention system that includes Regional Prevention Centers, targeted prevention programs, and Champions for a Drug Free Kentucky aimed at encouraging local community-based coalitions to promote science-based prevention programs that reduce alcohol, tobacco and other drug use among youth. Kentucky is considered a leader by many in the prevention field.

Although coalitions are widely popular and have grown by leaps and bounds in both the government and private sectors over the past two decades, significant controversy has emerged about their effectiveness and place among strategies for prevention and health promotion.

Welcome to the initial issue of the Prevention Evaluation Partnership newsletter, produced through a contract between the Kentucky Division of Substance Abuse and R.E.A.C.H. of Louisville . It is devoted to topics of interest for professionals in prevention, planning and evaluation throughout the Commonwealth of Kentucky. Every quarter, we will synthesize information from current research, regional data , and other timely articles related to planning and evaluation. We should note that this project is funded in part by Federal funds from the Center for Substance Abuse Prevention (CSAP); but does not necessarily reflect the views or policy of either CSAP or the Division of Substance Abuse.

So…What's the Controversy?

Recently, the effectiveness and value of community coalitions has come under question. They have sometimes been depicted as expensive, insufficient, weak, and lacking sufficient data to support their continued use. Conversely, they have been described as holistic and comprehensive, flexible, responsive, innovative, and as creating significant impacts on health promotion and substance abuse prevention.

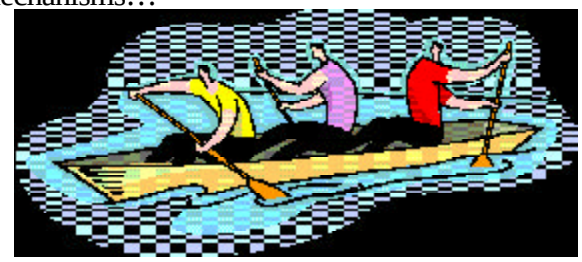
Yet…many of the research reviews on coalitions to date have reported less than hoped-for results, causing some to wonder if coalitions really "work." To address that question we turn our attention to the available research.

What does the literature tell us about community coalitions?

In a nutshell, the results are mixed and inconsistent when it comes to coalitions achieving outcomes. Some coalitions have demonstrated success while many haven't. So…what does the literature tell us about coalitions? The scarcity of published outcome studies tells us that the research on community coalitions (and partnerships and collaboratives) is small, not often rigorous, and potentially hard to find. Although the number of references to coalitions in scholarly journals has increased dramatically since 1980 (Berkowitz, 2001) there are still few outcome studies using methods considered to be most empirical (e.g. experimental design with random assignment and comparison groups). However, the literature is growing…what follows is a representative sampling of what the literature says about coalitions.

The case against coalitions

In a recent evaluation of the "Fighting Back" program, the largest privately funded community coalition program in the United States designed to address drug problems, researchers from the Pacific Institute for Research and Evaluation (PIRE) concluded that "coalitions are expensive to maintain and may not lend themselves to effective or well-implemented strategies" (Hallfors et al., 2002). Berkowitz (2001) acknowledges that "…the overall documented evidence to date for positive coalition outcomes is weak." Similarly, Kreuter et al. (2000) summarized a review of 68 studies on health-oriented coalitions by stating "…the published literature on community-based coalition strategies offers only marginal evidence that such approaches lead to health status/health systems change…" and "…funders and practitioners may be expecting too much from these increasingly popular mechanisms…"



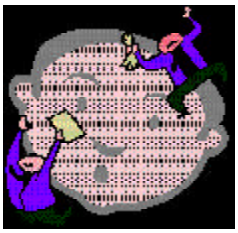
The case for coalitions

On the other hand, community coalitions have been reported to attain positive and dramatic outcomes in the literature. Coalitions have reached desired outcomes in several areas, such as disability advocacy, education, health clinics, access to prenatal care, housing for the mentally ill, and physical exercise Berkowitz, 2001) and arson prevention and immunization rates (Wandersman and Florin, 2003).

Within the area of substance abuse prevention specifically, Wandersman and Florin (2003) reviewed several community coalition efforts that demonstrated effectiveness. For instance, Hingson et al.(1996) studied the Saving Lives program in which "…community coalitions of multiple city departments and private citizens engaged in program initiatives to reduce drunk driving and speeding." Alcohol-related

driving accidents, injuries, and deaths were significantly lower than in comparison communities. Shaw, Rosati, Salzman, Coles and McGeary (1997) studied an ATOD coalition interested in reducing substance use and abuse among youth. Significant results were found for students' disapproval and perceived risk of tobacco and alcohol use, as well as for rates of alcohol use and heavy smoking by seniors (compared with national trends). In addition, there are many case studies or similar accounts of coalitions achieving positive outcomes.

Although the literature on coalitions is mixed, one area where researchers agree is that coalitions are inherently difficult to evaluate.



Why are coalitions so hard to evaluate?

At the heart of the coalition controversy are methodological issues that evaluators face when trying to determine the effectiveness of coalitions. Several authors (Gabriel, 2000; Berkowitz, 2001; DrugStrategies, 2001; Wandersman & Florin, 2003; Yin & Ware, 2000; Weiss, 1995) have delineated these issues nicely and they are summarized below.

First, coalitions (as a whole) are not well defined, making it difficult to replicate them or to consider them representative of other coalitions.

Second, in the real world (as opposed to a laboratory), there are many potential variables extraneous to the coalition that could interfere with the evaluation in some way. These variables could interfere by influencing the intended outcomes of the coalition or by causing departures from the intended implementation of the coalition. These extraneous variables (e.g. urban relocation, new government programs, changes in birth rate, etc.) are also different across communities and are not easily controlled for. In addition, they may interact and influence one another in myriad ways.

Third, most researchers consider "control" or "comparison" groups essential components of good research to ensure that any changes noted in the "treatment" group (e.g. a community) can be attributed to the intervention (e.g. coalition), and not to the extraneous variables. Ideally, comparison groups should be identical to the treatment group. However, as one can imagine, finding a suitable comparison community is extremely difficult and not often successful, making any generalizations cautious. There can also be some ethical problems in withholding services in one community while allowing them in another.

Fourth, coalitions often choose varied (not uniform) outcomes to measure their effectiveness, making comparisons of "results" across coalitions difficult. In addition, many of the outcome measures used (e.g. surveys, interviews) also carry their own problems (e.g. social desirability, self-selection bias). But other less problematic measures (e.g. aggregate or archival data) aren't always available or easy to access. Also, coalitions often identify broad, long-term outcomes (e.g. reduction in ATOD use) as measures of success. Yet, many communities often do not have good estimates of baseline data regarding drug use or other similar data, so comparison with outcomes could be questionable.

Fifth, coalitions often need years to show long-term results, making the need for intermediate outcomes a reality. Yet, many coalitions don't have a well-articulated theory linking their middle-range outcomes to long-term outcomes, thus creating an evaluation system that isn't "sensitive" to the real effects of the coalition.

Sixth, pressures associated with political and funding factors can inadvertently distort a coalition's functioning, altering the coalition's structure or integrity and creating havoc for an evaluator.

Seventh, coalitions may be hard to evaluate simply because of their very real complexity. They require much effort, organization, collaboration and planning. Traditional scientific processes may be "poorly equipped to address many of the realities and challenges of evaluating such complex community-based programs." (Gabriel, 2000).

What perspective can we take on coalitions?

Coalitions, from a developmental perspective, are still in their early childhood. They have only been around (and reported on in the literature) for two decades. Coalitions and similar types of community interventions have become popular mechanisms for community intervention. As Berkowitz (2001) stated, "Whether or not coalitions actually produce positive outcomes in practice, many community leaders apparently act as if they do, and this is indicative in itself." What perspective can we take on coalitions, given the current state of knowledge?

- It is too early to make any summative statements about whether or not coalitions "work", as there is much more to learn. Thus, abandoning the concept of coalitions is premature.
- The potential for positive outcomes is there, but may not be fully realized yet. Better refinements in evaluation methods, greater expressions of program theory, and measures with increased sensitivity are still needed.
- Coalitions may be a necessary, but not sufficient, part of the substance abuse prevention solution. Perhaps the importance of coalitions lies in the infrastructure and planning processes that they create, and not the specific interventions they promote (which can vary). Put another way, coalitions are a means to an end.
- Community readiness should be considered before implementing a coalition; communities may not be ready, or competent, to engage in this process.
- Our focus should be on "what works and what doesn't" with regards to coalitions, rather than focusing exclusively on whether or not they achieve positive long-term outcomes in a given community. Since coalitions are in an evolutionary process, this type of knowledge appears more appropriate at this time.

Elements of successful coalitions

Although coalitions are currently surrounded by controversy, several researchers have begun identifying elements of successful coalitions. Wolff (2001), drawing on his work as a practitioner with coalitions in Massachusetts and other states over the past 16 years, identified nine key dimensions to successful coalition building.

(1) Community readiness

The coalition is more likely to succeed when the impetus for the coalition comes from within the community, when the community has a history (even a small one) of past success with collaboratives, when the competition between and within community sectors is small, and when the community isn't already overrun with coalition activity.

(2) Intentionality

Clear plans, attainable goals, measurable objectives, and community ownership are critical to the success of the coalition.

(3) Structure and Organizational Capacity

While no single set structure is "best," adequately-staffed coalitions with effective communication mechanisms, clear structures for decision-making (e.g. hiring, spending) and for understanding roles and responsibilities are necessary for coalition success.

(4) Taking Action

Coalitions must keep the goal of important local community change in the forefront, while at the same time responding to the external environment that exerts an influence in the community. The ability to publicize the coalitions actions is also important.

(5) Membership

Successful coalitions pronounce their membership to be open and inclusive, with constant attention given to recruitment and retention of members; diversity of members is preferred.

(6) Leadership

Coalitions that develop leadership among members, rather than rely on a single charismatic leader tend to have greater longevity.

(7) Dollars and Resources

While funding in and of itself does not guarantee that any particular coalition will be successful, the degree of funding can have an influence on the way a coalition makes decisions, thus impacting the "type" of coalition that emerges.

(8) Relationships

Coalitions are a human enterprise and their success depends on the coalition's ability to create an environment where conflict can be surfaced and handled effectively and efficiently, rather than avoided. New relationships should be encouraged and developed both in and outside of the coalition, to allow for new ideas and to prevent the coalition from becoming stale.

(9) Technical Assistance

Coalitions often have compelling reasons for needing consultation, training, and general support. These directly contribute to coalition success. Two areas that seem most relevant to this discussion are "best practices" in prevention and science-based programs.

DrugStrategies (2001), integrating the work of CADCA, CSAP and other agencies identified six key elements that contribute to the development and success of coalitions.

(1) Clear mission and strategic plan – careful assessment, goals that are understandable to the community, developing a common language (e.g. theory of change or logic model), and community readiness.

(2) Broad, diverse coalition membership – coalitions need a critical mass of members with "social capital" who can provide quick access to businesses, media and funding sources; broad-based coalitions should include citizens, and professionals from service agencies, and grassroots representation from local residents and neighborhood groups. Tthe more diverse the membership, the more leverage they can have.

(3) Strong, continuing leadership – sustaining the commitment of members, strong skills in consensus building, bringing out hidden agendas and managing conflict, and preparing the coalition for a change in leadership are critical task to the maintain the longevity and ingenuity of a coalition.

(4) Diversified funding sources – relying on one major funding source can be detrimental, especially when institutionalization and sustainability of the coalition is a goal. Coalition members who can contribute to the procurement of alternate funding sources can be a vital piece of the pie.

(5) Training – Training can make a difference in the survival of a coalition; community readiness, membership recruitment, strategic planning, information about effective programs, how to interact with the media, and many more topics are often very relevant for coalition members to learn about, yet often get placed on the backburner.

(6) Evaluation – Evaluation is essential to the longevity of a coalition. Evidence of positive community impact is likely to be needed if funders are going to provide continued support.

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Some useful links:

Community Anti-Drug Coalitions of America
http://www.cadca.org/
Principles of Success in Building Community Coalitions
http://hsc.usf.edu/~kmbrown/Principles_in_Building_Successful_Coalitions.htm
Assessing Community Coalitions
http://www.drugstrategies.org/commcoal/ACC_Ch01.html
Kentucky Champions Community Coalition Page
http://www.champions.ky.gov/groups.htm
Kentucky ASAP Home Page
http://ky-asap.ky.gov/
Community Coalition Evaluation Tools
http://prevention.sph.sc.edu/Tools/coalition.htm
CSAP Community Asset Building and Healthy Communities Page
http://modelprograms.samhsa.gov/template_cf.cfm?page=links&linkCatID=2&from=cat

Never doubt that a small group of committed citizens can change the world. It's the only thing that ever has."

Margaret Mead

R.E.A.C.H. of Louisville, Inc.

Resources for Education, Adaptation, Health and Change

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